



**UNITED STATES DEPARTMENT OF JUSTICE
Drug Enforcement Administration**

[Docket No. 20-17]

Noah David, P.A.; Decision and Order

On March 9, 2020, a former Assistant Administrator, Diversion Control Division, of the Drug Enforcement Administration (hereinafter, DEA or Government), issued an Order to Show Cause (hereinafter, OSC) to Noah David, P.A. (hereinafter, Respondent) of Richmond, Virginia. Administrative Law Judge Exhibit (hereinafter, ALJX) 1 (OSC), at 1. The OSC proposed the revocation of Respondent's DEA Certificate of Registration No. MD3130717 (hereinafter, COR or registration) and the denial of "any pending application for renewal or modification of such registration and any applications for any other DEA registrations, pursuant to 21 U.S.C. 824(a)(4), because [Respondent's] registration is inconsistent with the public interest, as that term is defined in 21 U.S.C. 823(f)." *Id.*

On April 7, 2020, the Respondent timely requested a hearing, which commenced (and ended) on September 22, 2020, at the DEA Hearing Facility in Arlington, Virginia with the parties, counsel, and witnesses participating via video teleconference (VTC). On December 8, 2020, Chief Administrative Law Judge John J. Mulrooney, II (hereinafter, the Chief ALJ) issued his Recommended Rulings, Findings of Fact, Conclusions of Law and Decision of the Administrative Law Judge (hereinafter, Recommended Decision or RD). By letter dated January 5, 2021, the ALJ certified and transmitted the record to me for final Agency action. In that letter, the ALJ advised that neither party filed exceptions. Having reviewed the entire record, I adopt the ALJ's rulings, findings of fact, as modified, conclusions of law and recommended sanction with minor modifications, where noted herein.*^A

^A I have made minor modifications to the RD. I have substituted initials or titles for the names of witnesses and patients to protect their privacy and I have made minor, nonsubstantive, grammatical changes and nonsubstantive, conforming edits. Where I have made substantive changes, omitted language for brevity or relevance, or where I have added to or modified the ALJ's opinion, I have noted the edits with an asterisk, and I have included specific descriptions of the modifications in brackets following the asterisk or in footnotes marked with a letter and an

**RECOMMENDED RULINGS, FINDINGS OF FACT, CONCLUSIONS OF LAW, AND
DECISION OF THE ADMINISTRATIVE LAW JUDGE**

John J. Mulrooney, II
Chief Administrative Law Judge
December 8, 2020

^{*B}After carefully considering the testimony elicited at the hearing, the admitted exhibits, the arguments of counsel, and the record as a whole, I have set forth my recommended findings of fact and conclusions of law below.

I. FINDINGS OF FACT

A. Allegations

The Government alleges that the Respondent's COR should be revoked because he has committed acts which render his continued registration against the public interest. ALJX 1, at 1. Specifically, the Government contends that on numerous occasions between April 2014 and November 2018, the Respondent unlawfully prescribed controlled substances to his wife without establishing a *bona fide* practitioner-patient relationship and without properly documenting treatment. *Id.* at 3-4. The Government additionally alleges that the Respondent conspired with colleagues to unlawfully receive controlled substances. *Id.* at 4.

B. Stipulations

The parties entered into a robust set of factual stipulations which were accepted by the tribunal. Accordingly, the following factual matters are deemed conclusively established in this case:

1. The Respondent is registered with the DEA as a practitioner to handle controlled substances in Schedules II-V under DEA COR No. MD3130717 at 5211 West Broad Street, Suite 101, Richmond, Virginia 23230-3000.
2. DEA COR No. MD3130717 was issued on May 15, 2019 and expires by its own terms on June 30, 2022.

asterisk. Within those brackets and footnotes, the use of the personal pronoun "I" refers to myself—the Administrator.

^{*B} I have omitted the RD's discussion of the procedural history to avoid repetition with my introduction.

3. The Respondent is presently licensed as a physician assistant in Virginia under License No. 0110004505, which expires April 30, 2021.
4. Respondent Exhibit 1 is a true and correct copy of the Respondent's COR.
5. The Respondent prescribed the following controlled substances on the following dates to his wife, B.D.:

- (1) 11/28/2018: Oxycodone-Acetaminophen 5-325, 36 tablets
- (2) 11/20/2018: Oxycodone-Acetaminophen 5-325, 36 tablets
- (3) 11/08/2018: Oxycodone-Acetaminophen 5-325, 36 tablets
- (4) [10/30/2018: Oxycodone-Acetaminophen 5-325, 36 tablets]
- (5) 10/01/2018: Oxycodone-Acetaminophen 10-325, 18 tablets
- (6) 9/21/2018: Oxycodone-Acetaminophen 10-325, 18 tablets
- (7) 9/13/2018: Oxycodone-Acetaminophen 10-325, 18 tablets
- (8) 9/06/2018: Oxycodone-Acetaminophen 5-325, 60 tablets
- (9) 8/22/2018: Oxycodone-Acetaminophen 5-325, 60 tablets
- (10) 8/17/2018: Oxycodone-Acetaminophen 5-325, 60 tablets
- (11) 7/23/2018: Oxycodone-Acetaminophen 5-325, 42 tablets
- (12) 7/10/2018: Oxycodone-Acetaminophen 5-325, 84 tablets
- (13) 7/03/2018: Oxycodone-Acetaminophen 10-325, 18 tablets
- (14) 5/30/2018: Acetaminophen-Codeine #3, 60 tablets
- (15) 5/30/2018: Acetaminophen-Codeine #3, 60 tablets (refill)
- (16) 5/30/2018: Acetaminophen-Codeine #3, 60 tablets (refill)
- (17) 5/21/2018: Oxycodone-Acetaminophen 5-325, 12 tablets
- (18) 5/08/2018: Diazepam 5mg, 30 tablets
- (19) 4/24/2018: Oxycodone-Acetaminophen 10-325, 28 tablets
- (20) 3/16/2018: Oxycodone-Acetaminophen 10-325, 28 tablets
- (21) 2/15/2018: Oxycodone-Acetaminophen 10-325, 28 tablets

- (22) 2/09/2018: Oxycodone-Acetaminophen 10-325, 12 tablets
- (23) 1/23/2018: Oxycodone-Acetaminophen 10-325, 28 tablets
- (24) 1/19/2018: Oxycodone-Acetaminophen 10-325, 12 tablets
- (25) 1/05/2018: Oxycodone-Acetaminophen 10-325, 42 tablets
- (26) 1/03/2018: Oxycodone-Acetaminophen 10-325, 12 tablets
- (27) 12/22/2017: Oxycodone-Acetaminophen 10-325, 42 tablets
- (28) 12/08/2017: Oxycodone-Acetaminophen 10-325, 42 tablets
- (29) 11/21/2017: Oxycodone-Acetaminophen 10-325, 42 tablets
- (30) 11/08/2017: Oxycodone-Acetaminophen 10-325, 42 tablets
- (31) 10/25/2017: Oxycodone-Acetaminophen 10-325, 42 tablets
- (32) 10/06/2017: Oxycodone-Acetaminophen 10-325, 42 tablets
- (33) 9/22/2017: Oxycodone-Acetaminophen 10-325, 42 tablets
- (34) 9/14/2017: Diazepam 5mg, 90 tablets
- (35) 8/28/2017: Oxycodone-Acetaminophen 10-325, 56 tablets
- (36) 8/11/2017: Oxycodone-Acetaminophen 10-325, 56 tablets
- (37) 7/27/2017: Oxycodone-Acetaminophen 10-325, 56 tablets
- (38) 7/18/2017: Oxycodone-Acetaminophen 10-325, 21 tablets
- (39) 7/06/2017: Oxycodone-Acetaminophen 10-325, 28 tablets
- (40) 6/16/2017: Oxycodone-Acetaminophen 10-325, 25 tablets
- (41) 6/05/2017: Oxycodone-Acetaminophen 10-325, 28 tablets
- (42) 5/22/2017: Oxycodone-Acetaminophen 10-325, 48 tablets
- (43) 5/08/2017: Lorazepam 2mg, 60 tablets
- (44) 4/06/2017: Oxycodone-Acetaminophen 10-325, 48 tablets
- (45) 2/24/2017: Carisoprodol 250 mg, 90 tablets
- (46) 2/24/2017: Diazepam 2mg, 90 tablets
- (47) 2/07/2017: Oxycodone-Acetaminophen 10-325, 60 tablets

- (48) 12/28/2016: Oxycodone-Acetaminophen 10-325, 60 tablets
- (49) 12/02/2016: Oxycodone-Acetaminophen 10-325, 60 tablets
- (50) 11/11/2016: Oxycodone-Acetaminophen 10-325, 60 tablets
- (51) 10/24/2016: Oxycodone-Acetaminophen 10-325, 60 tablets
- (52) 10/06/2016: Oxycodone-Acetaminophen 10-325, 60 tablets
- (53) 9/26/2016: Oxycodone-Acetaminophen 10-325, 30 tablets
- (54) 9/14/2016: Oxycodone-Acetaminophen 10-325, 30 tablets
- (55) 8/29/2016: Oxycodone-Acetaminophen 10-325, 30 tablets
- (56) 8/16/2016: Hydrocodone-Acetaminophen 10-325, 30 tablets
- (57) 7/21/2016: Oxycodone-Acetaminophen 10-325, 60 tablets
- (58) 6/24/2016: Oxycodone-Acetaminophen 10-325, 30 tablets
- (59) 6/24/2016: Diazepam 2mg, 60 tablets
- (60) 6/10/2016: Oxycodone-Acetaminophen 10-325, 30 tablets
- (61) 5/13/2016: Oxycodone-Acetaminophen 10-325, 60 tablets
- (62) 4/21/2016: Oxycodone-Acetaminophen 10-325, 30 tablets
- (63) 3/25/2016: Oxycodone-Acetaminophen 10-325, 30 tablets
- (64) 2/25/2016: Oxycodone-Acetaminophen 10-325, 30 tablets
- (65) 2/05/2016: Oxycodone-Acetaminophen 10-325, 30 tablets
- (66) 10/12/2015: Oxycodone-Acetaminophen 10-325, 12 tablets
- (67) 10/09/2015: Oxycodone-Acetaminophen 10-325, 12 tablets
- (68) 9/25/2015: Oxycodone-Acetaminophen 10-325, 15 tablets
- (69) 5/29/2015: Oxycodone-Acetaminophen 10-325, 60 tablets
- (70) 5/29/2015: Diazepam 5mg, 60 tablets
- (71) 4/05/2015: Oxycodone-Acetaminophen 7.5-325, 60 tablets
- (72) 2/15/2015: Oxycodone-Acetaminophen 7.5-325, 30 tablets
- (73) 12/21/2014: Oxycodone-Acetaminophen 7.5-325, 30 tablets

- (74) 11/01/2014: Oxycodone-Acetaminophen 7.5-325, 90 tablets
 - (75) 9/11/2014: Hydrocodone-Acetaminophen 7.5-325. 45 tablets
 - (76) 7/24/2014: Hydrocodone-Acetaminophen 7.5-325, 30 tablets
 - (77) 6/04/2014: Hydrocodone-Acetaminophen 7.5-325, 15 tablets
 - (78) 4/15/2014: Hydrocodone-Acetaminophen 7.5-325, 30 tablets
6. The Respondent acted outside the usual course of professional practice in Virginia by issuing controlled substance prescriptions to his wife without establishing a bona fide practitioner-patient relationship and by failing to perform comprehensive examinations.
 7. The Respondent acted outside the usual course of professional practice in Virginia by issuing controlled substance prescriptions to his wife without properly documenting the treatment of his wife.
 8. The Respondent received prescriptions for controlled substances from L.K., P.A. on February 15, 2018, December 3, 2018, and December 4, 2018.
 9. The Respondent received a prescription for a controlled substance from J.A., P.A., on September 14, 2018.
 10. Oxycodone is a Schedule II controlled substance pursuant to 21 CFR 1308.12(b)(1)(xiv) and Va. Code Ann. § 54.1-3448.
 11. Hydrocodone is a Schedule II controlled substance pursuant to 21 CFR 1308.12(b)(1)(vi) and Va. Code Ann. § 54.1-3448.
 12. On March 3, 2019, the Respondent completed the Professional Boundaries and Ethics Course – Extended Edition, a continuing medical education course conducted by the Professional Boundaries Institute (PBI).
 13. Respondent Exhibit 2 is a true and correct copy of the Respondent’s certificate of completion for the PBI Professional Boundaries and Ethics Course – Extended Edition continuing medical education course.

14. The Respondent completed a PBI Maintenance and Accountability Seminars continuing medical education course of July 11, 2019.
15. Respondent Exhibit 3 is a true and correct copy of the Respondent's certificate of completion for the PBI Maintenance and Accountability Seminars continuing medical education course.
16. The Respondent completed a VCU Health's Safe Opiate Prescribing continuing medical education course on January 1, 2019.
17. Respondent Exhibit 4 is a true and correct copy of the Respondent's certificate of completion for VCU Health's Safe Opiate Prescribing continuing medical education course.

C. Government's Case

The Government's case consisted of testimony from a diversion investigator assigned to the case that yielded these proceedings and a senior investigator from the Virginia Department of Health Professions.

1. Diversion Investigator R.P.

The Government presented the testimony of Diversion Investigator RP. (hereinafter, the DI). The DI testified that he has been a DI for approximately seven years and is currently stationed at the Richmond field office. Tr. 11-12. The DI's testimony narrated the course of the investigation and authenticated a number of Government Exhibits. *Id.* at 11-40.

The DI testified that he worked with Task Force Officer C.E. (hereinafter, the TFO) in the investigation into the Respondent, a physician assistant (PA). *Id.* at 13-14. Their investigation began when the TFO was contacted by Senior Investigator K.L. at the Department of Health Professions (DHP). *Id.* at 13, 15. Senior Investigator K.L. informed DEA that during a DHP investigation of the Respondent, the Respondent admitted to "issuing prescriptions

without legitimate use” to his wife, father-in-law, a family friend, and a colleague’s spouse.¹ *Id.* at 15. She then provided a copy of her investigative report to DEA. *Id.* at 15.

In investigating the Respondent’s prescribing history, the DI generated a report from the Prescription Monitoring Program (PMP) regarding the Respondent’s prescribing. *Id.* at 16. The DI noted that the Respondent issued his first prescription to his wife approximately a month-and-a-half after he received his DEA COR. *Id.* at 16-17. The DI also accessed the PMP to generate a report relative to the controlled substance prescriptions that had been issued to Respondent’s wife.² *Id.* at 17. The report revealed that over eighty-five prescriptions were written for her by the Respondent during the previous period of almost five years. *Id.* at 17. Seventy-two of those eighty-five prescriptions were for pain medications. *Id.* at 18. The DI testified that in analyzing the report, he perceived patterns wherein the Respondent, in the DI’s view, prescribed a high quantity of controlled substances for what the DI classified as a relatively short span of time. *Id.* at 18-19. The DI concluded that this pattern could support a possible indication of drug diversion. *Id.* The DI found it further curious that the controlled substance prescriptions that the Respondent wrote to his wife used both her maiden name and married name, so that, in the DI’s assessment of things, the Respondent “was actually issuing prescriptions to what appeared at face value to be two different individuals.” *Id.* at 20.

In addition to a brief encounter with the Respondent, the DI interviewed three individuals: the pharmacist who filed the initial complaint with DHP; a PA coworker of the Respondent, R.K.; and a supervising physician at Radiology Associates of Richmond (RAR), the radiology practice where the Respondent was employed during the events that form the basis of this case.³ *Id.* at 23-31.

¹ The findings and recommendations in this Recommended Decision are restricted to the charged and preponderantly established misconduct.

² The BD PMP Report, which temporally included all controlled substance prescriptions written to her from January 1, 2014 to the date it was generated on December 18, 2018, was received into the record. GX 3.

³ The DI attempted to interview another PA, J.A., but learned that he was on vacation out of the country and the DI did not attempt to interview him when he returned. *Id.* at 31.

The pharmacist told the DI that she noticed that the Respondent was receiving controlled substance prescriptions from colleagues, and that he was writing prescriptions to his wife under her married and maiden name. *Id.* at 23-24. During her interview with the DI, R.K. admitted that she issued several prescriptions to the Respondent without performing a medical exam or documenting the prescriptions and treatment.⁴ *Id.* at 25-26. Regarding one of the prescriptions, R.K. explained that she wrote the scrip because the Respondent had hurt his hand; “she could visibly see that it was affecting his procedures” but she “did not perform an examination, [and] she wrote a prescription based off of what she had observed from afar.” *Id.* at 28. The DI testified that R.K. told him that she issued prescriptions to the Respondent because “she trusted him. She trusted that he wasn’t taking advantage of her because he had . . . mentored her . . . when she first came into her profession” and “she didn’t think that he would ask her to do anything that was wrong or illegal.” *Id.* at 25-26. R.K. also related to the DI that as the Respondent continued to request more prescriptions, she became hesitant and progressively uncomfortable with writing him prescriptions, but continued to anyway. *Id.* at 28.

During his interview, the supervising physician, who supervised the Respondent towards the end of the Respondent’s time at RAR, told the DI that the Respondent “received training on issuing legitimate prescriptions.” *Id.* at 29-30. According to the DI, the supervising physician also said that he “had no reason to believe that [the Respondent] had misinterpreted what the regulations were when it comes to issuing prescriptions.”⁵ *Id.*

The DI presented as an objective regulator and investigator with no discernable motive to fabricate or exaggerate. The testimony of this witness was sufficiently detailed, plausible, and internally consistent to be afforded full credibility in this case.

⁴ The DI testified that the interview took place at the U.S. Attorney’s Office and was attended by the TFO, an Assistant U.S. Attorney (AUSA), and a legal representative from RAR. *Id.* at 26-27. R.K. was not under arrest during the interview, forced to answer any questions, or offered anything in exchange for cooperating with the DI or the AUSA. *Id.* at 26-28.

⁵ The DI testified that the supervising physician was not forced to answer any questions, the interview took place at the U.S. Attorney’s Office, and was attended by the TFO, an AUSA, and a legal representative from RAR. *Id.* at 30-31.

2. Senior Investigator K.L.

The Government also presented testimony from DHP Senior Investigator K.L. (hereinafter, the DHP SI). The DHP SI testified that she has been a senior investigator with DHP⁶ for eighteen years, a registered nurse for over thirty years, a master's prepared registered nurse for over twenty-five years, and is currently stationed as an investigator in Henrico County. *Id.* at 44-45 and 48.

The Respondent came to the attention of DHP when the previously-mentioned pharmacist filed a formal complaint on or around December 2018 and the DHP SI was assigned to conduct the investigation. *Id.* at 52-54 and 61-62. The DHP SI testified that during the course of her investigation, she obtained the Respondent's PMP report, collected copies of relevant controlled substance scrips, and interviewed the previously-mentioned pharmacist, RAR employees, and the Respondent. *Id.* at 55. Around the end of January 2019, the DHP SI interviewed the Respondent and questioned him on the prescriptions he issued to his wife and the prescriptions written in his name by his PA colleagues, R.K. and J.A. *Id.* at 63-65. During the course of their conversation, the Respondent informed the DHP SI that some of the controlled substance prescriptions he received from his colleagues were to treat hand pain and cold congestion, but conceded that at no time did his PA colleagues perform any sort of assessment or exam. *Id.* at 65.

According to the DHP SI, the PA colleagues confirmed that "they did not conduct any type of exam on [the Respondent] and [that] they did not document any of their assessments on him when they provided the prescriptions that he personally requested them to write." *Id.* at 57. One of the medications that R.K. wrote for the Respondent was a combination of codeine and guaifenesin, which heightened the concern of the previously-mentioned pharmacist because the medication was not even dispensable as written. *Id.* at 66-67. J.A. told the DHP SI that the

⁶ The DHP SI explained that DHP is "the licensing and discipline entity for the Commonwealth of Virginia that licenses healthcare provider[s]," including physician assistants. *Id.* at 46-47.

Respondent approached him for medication, supposedly to treat a migraine. *Id.* at 69-70. J.A. related to the DHP SI that he knew the controlled substance the Respondent requested was not a typical treatment for migraines, and so decided that he would only prescribe a limited quantity of four pills. *Id.* at 70.

The DHP SI's investigation culminated in a report for the Virginia Board of Medicine that reflected that the Respondent wrote controlled substance prescriptions to his wife with no corroborating records, and that the Respondent received controlled substance prescriptions from his PA colleagues with no corroborating records. *Id.* at 67-68.

Like the DI, the DHP SI presented as an objective regulator and investigator with no discernable motive to fabricate or exaggerate. The testimony of this witness was sufficiently detailed, plausible, and internally consistent to be afforded full credibility in this case.

D. Respondent's Case

The Respondent's affirmative case at the hearing consisted exclusively of his own testimony. The Respondent testified that he received his Bachelor of Arts degree in Biology from Lewis & Clark College in 2003, followed by a Master's degree in Physician Assistant Studies from James Madison University in 2013. Tr. 87. He has been a licensed physician assistant in Virginia since 2014. *Id.* at 90-91. After receiving his license, the Respondent worked at the Center for Gastrointestinal Health in Petersburg, Virginia. *Id.* at 87-88, 94. At this first job the Respondent possessed the requisite authority to prescribe controlled substances, but by his recollection an occasion to do so never arose. *Id.* at 94-95. The Respondent testified that he left this job amicably in March 2015 in order to find another job that would provide family health benefits. *Id.* at 95.

In March 2015, the Respondent began working for RAR in Richmond, Virginia, where he specialized in interventional radiology. *Id.* at 96. As a physician assistant at RAR, the Respondent exercised his COR authority to prescribe controlled substances. *Id.* at 97. Although RAR is a practice devoted to interventional radiology, he explained that the procedure-based

nature of the practice did sometimes call for the prescribing of post-procedure controlled pain medications under established protocols. *Id.* at 98-99. The Respondent explained that at RAR, prescribing within the usual course of professional practice meant “[f]ollowing the protocols of the supervising physician.” *Id.* at 99-100. The protocols involved meeting with the supervising physician and acquiring from the physician a written treatment plan for each patient. *Id.* at 100. The Respondent also testified that in the course of prescribing a patient a controlled substance he would conduct an “extremely” comprehensive exam, including a full history and physical, and then “thoroughly” document the findings of the examinations. *Id.* at 100. Once he was notified of DHP’s investigation into him, the Respondent transparently notified his supervisors at RAR. *Id.* at 101. He was initially put on administrative leave, but then was afforded the option to resign from the practice, which he exercised in February 2019. *Id.* at 101.

In April 2019, the Respondent secured employment at Alliance Physical Therapy, a physical therapy clinic.⁷ *Id.* at 102. The Respondent explained that Alliance Physical Therapy has a strong policy against prescribing controlled substances to patients, and that he “wanted that job because [he] knew that this was something that just [he] needed to not do. And [he] needed it not to be available.”⁸ *Id.* at 102. However, in one instance, extenuating circumstances arose that required prescribing Tramadol to a patient, which the Respondent prescribed only after conferring with his supervising physician who then made the decision to prescribe a controlled substance. *Id.* at 103-04.

In addressing the allegations brought by the Government, the Respondent admitted to improperly prescribing controlled substances to his wife and offered testimony to potentially help clarify the surrounding circumstances. In 2012, when the Respondent noticed that his wife (B.D.) had developed a severe limp after running, and upon his insistence, his wife consulted an

⁷ The Respondent testified that he worked at Alliance Physical Therapy for one year before he was furloughed in April 2020 due to the COVID-19 pandemic. *Id.* at 102, 104. He has since interviewed with Commonwealth Radiology, “another radiologist/interventional radiology group,” and the Respondent testified that he was transparent with his potential future employers regarding the relevant investigations. *Id.* at 105.

⁸ The issue of why the Respondent, who is seeking to continue his status as a DEA registrant, needed to isolate himself from conducting the regulated activity he now seeks to preserve was never developed at the hearing.

orthopedist. *Id.* at 105. The orthopedist diagnosed B.D. with a CAM lesion on the head of her femur and subsequently performed surgery to reconstruct her hip and treat the CAM lesion. *Id.* at 105-07. According to the Respondent,⁹ after the surgery his wife experienced increased pain and developed arthritis, which was diagnosed by orthopedist Dr. J.H. *Id.* at 107-09. Dr. J.H. treated B.D. with non-steroidal anti-inflammatories (NSAIDs), but she developed an ulcer. *Id.* at 109-10. To address her pain, B.D. then took part in physical therapy, yoga, swimming, different types of NSAIDs, Tylenol, and then received injections. *Id.* at 110. The Respondent testified that injections helped with his wife's symptoms, but not long-term. *Id.* at 110-11. In April 2014, after being treated by Dr. J.H. throughout, and not seeking care from another physician, B.D. was "at her wits' end," "was distraught," "was in pain every day," "was having a hard time just getting around the house," "things got desperate," and she asked the Respondent for something to relieve her pain. *Id.* at 111-12. The Respondent wrote his wife a controlled substance prescription, but upon circumspection, if he "could go back, [he] certainly would not do it again." *Id.* at 112.

The Respondent openly admitted that the controlled substance prescriptions he wrote to his wife between April 2014 and November 2018 were unlawful, unethical, unprofessional, wrong, and not valid, and that he even knew it was wrong at the time.¹⁰ *Id.* at 113-14. In explaining his logic behind writing prescriptions that were unlawful and wrong, the Respondent offered the following:

I mean, it was really a matter of convenience. I saw her quality of life improve. And it just snowballed because of convenience. And through the years of doing it, my anxiety was – got worse and worse. *I knew – I knew it was wrong.* And it's really just – it's fortunate it didn't hurt our relationship, but it made my life quite distraught. *Id.* at 114 (emphasis supplied).

⁹ No corroborating medical records or other documentation was offered by the Respondent in support of his wife's purported medical issues.

¹⁰ The Respondent also admitted that he prescribed controlled substances to his wife while she was pregnant and that issuing such prescriptions while she was pregnant without proper supervision was potentially dangerous (although the wife's obstetrician was aware of the narcotics she was taking). *Id.* at 152-54.

Counsel for the Respondent read through Allegations 8-11 from the OSC, asking for each whether the Respondent understood the allegation and whether the Respondent agreed with the allegation. *Id.* at 133-36. The Respondent testified that he understood and agreed with Allegations 8-11. *Id.* at 133-36.

The Respondent also admitted to improperly receiving controlled substance prescriptions from his PA colleagues. It is the Respondent's recollection that he first approached R.K. for a controlled substance prescription after he underwent hand surgery and his treating surgeon denied him pain medication.¹¹ *Id.* at 137-38. The Respondent explained that acquiring the prescription from R.K. was wrong and that he knew he was asking her to violate RAR's protocols that required PAs to prescribe controlled substances under the guidance of a physician. *Id.* at 139-40. The Respondent also openly admitted that he agreed with the Government's allegations that he did not have a *bona fide* practitioner-patient relationship with his PA colleagues, that they did not document the treatment they rendered to him, and that he received the controlled substance prescriptions from them outside the usual course of professional practice. *Id.* at 143-44. In his own words, the Respondent described his conduct in regards to receiving the relevant prescriptions from his PA colleagues as "unprofessional." *Id.* at 144-45. The Respondent testified that he took advantage of his colleagues because he knew he could not get the prescriptions he wanted from a doctor and that he knew his PA colleagues were not keeping medical records of his treatment because they could be disciplined for doing so. *Id.* at 151-52. Based on his PA colleagues' conduct, the Respondent agreed that they both knew that their conduct in prescribing controlled substances to the Respondent was improper. *Id.* at 153.

The Respondent testified that in the wake of the allegations against him, he took three continuing medical education (CME) courses to improve his practice. RX 2-4; Tr. 117-119, 127-28. He completed an in-person, thirty-four hour professional boundaries course on March 1

¹¹ Again, the Respondent offered no form of corroboration for any of the medical conditions he ascribed to himself or his wife.

through March 3, 2019. RX 2; Tr. at 118. The Respondent testified that the course taught him about “getting in the habit of saying no” as foundational for operating within professional boundaries. Tr. at 118. The Respondent also testified that he participated in a twelve-week telephonic-contact course on maintenance and accountability that was completed on July 11, 2019 (Phone Follow-up Exercise). RX 3; Tr. at 122-23. The Phone Follow-up Exercise was an extension of the first and consisted of twelve one-hour weekly seminars conducted via telephone. Tr. at 122-23. The Respondent explained that the Phone Follow-up Exercise afforded him the opportunity to express the remorse, embarrassment, and anger he felt over his actions, as well as share the tools he was developing to maintain professional boundaries (including taking a position at a practice with a non-narcotic policy, refusing a prescription pad, and having a habit of saying no). *Id.* at 126-27. In addition to the professional boundaries course and the Phone Follow-up Exercise, the Respondent testified that he completed a two-hour online course in safe opiate prescribing through Virginia Commonwealth University’s medical school.¹² RX 4; Tr. at 127-29.

The Respondent also testified that moving forward, he intends to comply with all laws regarding controlled substances and that he “will only prescribe when appropriate and only to patients when it’s well documented and for an appropriate reason.” Tr. at 132. He acknowledged the severity of his repeated intentional acts, but also feels that this has only ever been a personal issue and that his misguidance has never lapsed over into affecting the public. *Id.* at 147-48.

As is generally the case, the Respondent unarguably possesses the greatest interest in the outcome of these proceedings, and hence, the greatest motivation to enhance, modify, or even fabricate his testimony. While the Respondent’s testimony was generally consistent, it was not always free from confusing aspects. He stated and admitted that he issued controlled substances

¹² Inexplicably, the opiate prescribing course certificate indicates that the course was conducted on “July 11, 2017 – December 31, 2020.” RX 4.

to his wife for years knowing that it was wrong, and explained that he understood that it was unlawful, unprofessional, and wrong, which is information that he undoubtedly possessed while the misconduct was underway. The Respondent presented as a knowledgeable professional who, at all times relevant, understood the rules, but yet engaged in an extended course of conduct that he knew was unprofessional, illegal, and dangerous.¹³ He even allowed that his actions caused him a considerable level of consternation. The Respondent's testimony that he was aware of and adhered to detailed examination and prescribing protocols regarding RAR patients stands in no small measure of conflict with his extended level of unlawful prescribing, punctuated by the calculated practice of interchanging his wife's maiden and married names. Odd also was the Respondent's assertion that after the commencement of the DHP investigation he began working at a physical therapy clinic that has a strong policy against prescribing controlled substances to patients. He explained that he "wanted that job because [he] knew that this was something that just [he] needed to not do. And [he] needed it not to be available." Tr. 102. The testimony is almost reminiscent of an addictive personality seeking to avoid the temptation of the focus of the addiction; and yet, the Respondent seeks to continue prescribing controlled substances. In an apparent abandonment of his prescribing avoidance, upon his COVID-related furlough, the Respondent is currently pursuing employment at Commonwealth Radiology, where, if successful, it appears his duties will mirror those at RAR, including his controlled substance prescribing responsibilities. It is not so much that the Respondent is incredible, he is not that. It is more that his presentation was confusing, and at times enigmatic.

Other facts necessary for a disposition of this case are set forth in the balance of this Recommended Decision.

II. DISCUSSION

A. Public Interest Determination: The Standard

Under 21 U.S.C. 824(a)(4), the Agency may revoke the COR of a registrant if the

¹³ Indeed, no physician who treated his wife before or after his misconduct prescribed controlled substances for her.

registrant “has committed such acts as would render his registration . . . inconsistent with the public interest.” 21 U.S.C. 824(a)(4). Congress has circumscribed the definition of public interest in this context by directing consideration of the following factors:

- (1) The recommendation of the appropriate State licensing board or professional disciplinary authority.
- (2) The [registrant’s] experience in dispensing, or conducting research with respect to controlled substances.
- (3) The [registrant’s] conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.
- (4) Compliance with applicable State, Federal, or local laws relating to controlled substances.
- (5) Such other conduct which may threaten the public health and safety. 21 U.S.C. 823(f).

“These factors are to be considered in the disjunctive.” *Robert A. Leslie, M.D.*, 68 FR 15,227, 15,230 (2003). Any one or a combination of factors may be relied upon, and when exercising authority as an impartial adjudicator, the Agency may properly give each factor whatever weight it deems appropriate in determining whether a registrant’s COR should be revoked. *Id.*; see *Morall v. DEA*, 412 F.3d 165, 173-74 (D.C. Cir. 2005). Moreover, the Agency is “not required to make findings as to all of the factors,” *Hoxie v. DEA*, 419 F.3d 477, 482 (6th Cir. 2005); *Morall*, 412 F.3d at 173, and is not required to discuss consideration of each factor in equal detail, or even every factor in any given level of detail, *Trawick v. DEA*, 861 F.2d 72, 76 (4th Cir. 1988) (holding that the Administrator’s obligation to explain the decision rationale may be satisfied even if only minimal consideration is given to the relevant factors, and that remand is required only when it is unclear whether the relevant factors were considered at all). The balancing of the public interest factors “is not a contest in which score is kept; the Agency is not required to mechanically count up the factors and determine how many favor the Government

and how many favor the registrant. Rather, it is an inquiry which focuses on protecting the public interest” *Jayam Krishna-Iyer, M.D.*, 74 FR 459, 462 (2009).

In adjudicating a revocation of a DEA COR, the DEA has the burden of proving that the requirements for the revocation it seeks are satisfied. 21 CFR 1301.44(e). Where the Government has met this burden by making a *prima facie* case for revocation of a registrant’s COR, the burden of production then shifts to the registrant to show that, given the totality of the facts and circumstances in the record, revoking the registrant’s COR would not be appropriate. *Med. Shoppe-Jonesborough*, 73 FR 364, 387 (2008). Further, “to rebut the Government’s *prima facie* case, [a registrant] is required not only to accept responsibility for [the established] misconduct, but also to demonstrate what corrective measures [have been] undertaken to prevent the re-occurrence of similar acts.” *Jeri Hassman, M.D.*, 75 FR 8194, 8236 (2010); *accord Krishna-Iyer*, 74 FR at 464 n.8. In determining whether and to what extent a sanction is appropriate, consideration must be given to both the egregiousness of the offense established by the Government’s evidence and the Agency’s interest in both specific and general deterrence. *David A. Ruben, M.D.*, 78 FR 38,363, 38,364, 38,385 (2013).

Normal hardships to the registrant, and even to the surrounding community, which are attendant upon lack of registration, are not a relevant consideration. *See Linda Sue Cheek, M.D.*, 76 FR 66,972, 66,972-73 (2011); *Gregory D. Owens, D.D.S.*, 74 FR 36,751, 36,757 (2009). Further, the Agency’s conclusion that “past performance is the best predictor of future performance” has been sustained on review in the courts, *Alra Labs., Inc. v. DEA*, 54 F.3d 450, 452 (7th Cir. 1995), as has the Agency’s consistent policy of strongly weighing whether a registrant who has committed acts inconsistent with the public interest has accepted responsibility and demonstrated that he or she will not engage in future misconduct. *Hoxie*, 419 F.3d at 483.¹⁴

¹⁴ The Agency has repeatedly upheld this policy. *See Ronald Lynch, M.D.*, 75 FR 78,745, 78,754 (2010) (holding that the respondent’s attempts to minimize misconduct undermined acceptance of responsibility); *George Mathew, M.D.*, 75 FR 66138, 66140, 66145, 66148 (2010); *George C. Aycock, M.D.*, 74 FR 17,529, 17,543 (2009); *Krishna-*

Although the burden of proof at this administrative hearing is a preponderance-of-the-evidence standard, *see Steadman v. SEC*, 450 U.S. 91, 100-03 (1981), the Agency’s ultimate factual findings will be sustained on review to the extent they are supported by “substantial evidence,” *Hoxie*, 419 F.3d at 481. While “the possibility of drawing two inconsistent conclusions from the evidence” does not limit the Administrator’s ability to find facts on either side of the contested issues in the case, *Shatz v. U.S. Dep’t of Justice*, 873 F.2d 1089, 1092 (8th Cir. 1989) (internal citation omitted), all “important aspect[s] of the problem,” such as a respondent’s defense or explanation that runs counter to the Government’s evidence, must be considered, *Wedgewood Vill. Pharmacy v. DEA*, 509 F.3d 541, 549 (D.C. Cir. 2007); *see Humphreys v. DEA*, 96 F.3d 658, 663 (3d Cir. 1996). The ultimate disposition of the case “must be ‘in accordance with’ the weight of the evidence, not simply supported by enough evidence ‘to justify, if the trial were to a jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury.’” *Steadman*, 450 U.S. at 99 (quoting *Consolo v. FMC*, 303 U.S. 607, 620 (1966)).

Regarding the exercise of discretionary authority, the courts have recognized that gross deviations from past agency precedent must be adequately supported, *Morall*, 412 F.3d at 183, but mere unevenness in application does not, standing alone, render a particular discretionary action unwarranted. *Chein v. DEA*, 533 F.3d 828, 835 (D.C. Cir. 2008), *cert. denied*, 555 U.S. 1139 (2009); *cf. Dep’t of Homeland Security v. Regents of Univ. of Cal.*, 140 S. Ct. 1891, 1913 (2020) (holding that an agency must carefully justify significant departures from prior policy where reliance interests are implicated). It is well settled that, because the Administrative Law Judge has had the opportunity to observe the demeanor and conduct of hearing witnesses, the factual findings set forth in this Recommended Decision are entitled to significant deference, *see Universal Camera Corp. v. NLRB*, 340 U.S. 474, 496 (1951), and that this Recommended

Iyer, 74 FR at 463; *Steven M. Abbadessa, D.O.*, 74 FR 10,077, 10,078 (2009); *Med. Shoppe-Jonesborough*, 73 FR at 387.

Decision constitutes an important part of the record that must be considered in the Agency's final decision, *see Morall*, 412 F.3d at 179. However, any recommendations set forth herein regarding the exercise of discretion are by no means binding on the Administrator and do not limit the exercise of that discretion. *See* 5 U.S.C. 557(b); *River Forest Pharmacy, Inc. v. DEA*, 501 F.2d 1202, 1206 (7th Cir. 1974); *Attorney General's Manual on the Administrative Procedure Act* § 8(a) (1947).

B. Factors Two and Four: The Respondent's Experience Dispensing Controlled Substances and Compliance with Federal, State, and Local Law

The Government has founded its theory for sanction exclusively on Public Interest Factors Two (the Respondent's experience conducting regulated activity) and Four (the Respondent's compliance with state and federal laws related to controlled substances), and it is under those two factors that the lion's share of the evidence of record relates.¹⁵ In this case, the gravamen of the allegations in the OSC, as well as the factual concentration of much of the evidence presented, share as a principal focus the Respondent's prescribing of controlled substances to his (non-patient) wife, and his role in receiving controlled substance prescriptions issued to him by his DEA registrant co-workers. The structure of the Government's theory, and the Respondent's case to meet that theory, renders it analytically logical to consider Public Interest Factors Two and Four together regarding the Respondent's prescribing, and Factor Four

¹⁵ The record contains no recommendation from any state licensing board or professional disciplinary authority (Factor One), but, aside from cases establishing a complete lack of state authority, the presence or absence of such a recommendation has not historically been a case-dispositive issue under the Agency's precedent. *Patrick W. Stodola, M.D.*, 74 FR 20,727, 20,730 (2009); *Krishna-Iyer*, 74 FR at 461. Similarly, there is no record evidence of a conviction record relating to regulated activity (Factor Three). Even apart from the fact that the plain language of this factor does not appear to emphasize the absence of such a conviction record, myriad considerations are factored into a decision to initiate, pursue, and dispose of criminal proceedings by federal, state, and local prosecution authorities which lessen the logical impact of the absence of such a record. *See Robert L. Dougherty, M.D.*, 76 FR 16823, 16833 n.13 (2011); *Dewey C. MacKay, M.D.*, 75 FR 49,956, 49,973 (2010) ("[W]hile a history of criminal convictions for offenses involving the distribution or dispensing of controlled substances is a highly relevant consideration, there are any number of reasons why a registrant may not have been convicted of such an offense, and thus, the absence of such a conviction is of considerably less consequence in the public interest inquiry."), *aff'd*, *MacKay v. DEA*, 664 F.3d 808 (10th Cir. 2011); *Ladapo O. Shyngle, M.D.*, 74 FR 6056, 6057 n.2 (2009). Therefore, the absence of criminal convictions militates neither for nor against the revocation sought by the Government. Because the Government's allegations and evidence fit squarely within the parameters of Factors Two and Four and do not raise "other conduct which may threaten the public health and safety," 21 U.S.C. 823(f)(5), Factor Five militates neither for nor against the sanction sought by the Government in this case.

independently with respect to the role the Respondent played in securing controlled substance prescriptions from his colleagues. That being said, Factors Two and Four involve analysis of both common and distinct considerations.

Regarding Factor Two, the Respondent is a credentialed and experienced physician assistant who has been treating patients, in various capacities, for around six years. Tr. 90. Likewise, the evidence of record points to issues regarding controlled substance prescribing to his wife (B.D.) and himself; and there is no evidence of record that the Respondent has been the subject of discipline by state or federal authorities relative to his controlled substance prescribing to legitimate patients.^{*C} While there is no evidence to contradict the Respondent's contention that he has never let his prescribing deficiencies seep over into other aspects of his medical practice, the Agency has long found that benign experience cannot overcome intentional misconduct, and that the misconduct established by record evidence is considered under both Factors Two and Four. *See Roberto Zayas, M.D.*, 82 FR 21,410, 21,422 n.27 (2017) (announcing that "misconduct is misconduct whether it is relevant under Factor Two, Factor Four, or Factor Five, or multiple factors"). It is beyond argument that every scrap of established misconduct in this case is of the intentional variety. Thus, the balance of the evidence related to Factor Two []will be considered below together with Factor Four.

As discussed, *supra*, Factor Four compels consideration of the Respondent's compliance with state and federal laws related to controlled substances. The DEA regulations provide that to be effective, a prescription must be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice. 21 CFR 1306.04(a). The Supreme Court has opined that, "the prescription requirement . . . ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse." *Gonzales v. Oregon*, 546 U.S. 243, 274 (2006). Further, the Agency's authority to revoke a registration is not limited to instances where a practitioner has intentionally diverted controlled substances.

^{*C} Omitted for brevity.

Bienvenido Tan, 76 FR 17,673, 17,689 (2011); *see Dewey C. MacKay*, 75 FR at 49,974 (holding that revocation is not precluded merely because the conduct was “unintentional, innocent, or devoid of improper motive”) (citation omitted).

To effectuate the dual goals of conquering drug abuse and controlling both legitimate and illegitimate traffic in controlled substances, “Congress devised a closed regulatory system making it unlawful to manufacture, distribute, dispense, or possess any controlled substance except in a manner authorized by the [Controlled Substances Act (CSA)].” *Gonzales v. Raich*, 545 U.S. 1, 13 (2005). Consistent with the maintenance of that closed regulatory system, subject to limited exceptions not relevant here, a controlled substance may only be dispensed upon a prescription issued by a practitioner, and such a prescription is unlawful unless it is “issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.” 21 CFR 1306.04(a); *see* 21 U.S.C. 829. Furthermore, “[a]n order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent of [21 U.S.C. 829] and the person knowingly . . . issuing it, shall be subject to the penalties provided for violations of the provisions of law related to controlled substances.” 21 CFR 1306.04(a).

The prescription requirement is designed to ensure that controlled substances are used under the supervision of a doctor, as a bulwark against the risk of addiction and recreational abuse. *George C. Aycock, M.D.*, 74 FR 17,529, 17,541 (2009) (citing *Gonzales*, 546 U.S. at 274); *see also United States v. Moore*, 423 U.S. 122, 135, 142-43 (1975) (noting that evidence established that a physician exceeded the bounds of professional practice when he gave inadequate examinations or none at all, ignored the results of the tests he did make, and took no precautions against misuse and diversion). The prescription requirement likewise stands as a proscription against doctors “peddling to patients who crave the drugs for those prohibited uses.” *Gonzales*, 546 U.S. at 274. A registered practitioner is authorized to dispense, which the CSA defines as “to deliver a controlled substance to an ultimate user . . . by, or pursuant to the lawful

order of a practitioner.” 21 U.S.C. 802(10); *see also* *Rose Mary Jacinta Lewis*, 72 FR 4035, 4040 (2007). The courts have sustained criminal convictions based on the issuing of illegitimate prescriptions where physicians conducted no physical examinations or sham physical examinations. *United States v. Alerre*, 430 F.3d 681, 690-91 (4th Cir. 2005), *cert. denied*, 574 U.S. 1113 (2006); *United States v. Norris*, 780 F.2d 1207, 1209 (5th Cir. 1986).

“Under the CSA, it is fundamental that a practitioner must establish and maintain a [*bona fide*] doctor-patient relationship in order to act in the usual course of . . . professional practice and to issue a prescription for a legitimate medical purpose.” *Dewey C. Mackay, M.D.*, 75 FR 49,956, 49,973 (2010) (citation omitted); *Stodola*, 74 FR at 20,731; *Shyngle*, 74 FR at 6057-58. The CSA generally looks to state law to determine whether a *bona fide* doctor-patient relationship was established and maintained. *Stodola*, 74 FR at 20,731; *Shyngle*, 74 FR at 6058; *Kamir Garces-Mejias, M.D.*, 72 FR 54,931, 54,935 (2007); *United Prescription Servs., Inc.*, 72 FR 50,397, 50,407 (2007).

The CSA authorizes the “regulat[ion of] medical practice so far as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood,” *Gonzales*, 546 U.S. at 909-10, and the Agency also evaluates cognizant state standards. *Joseph Gaudio, M.D.*, 74 FR 10,083, 10,090 (2009); *Garces-Mejias*, 72 FR at 54,935; *United Prescription Services, Inc.*, 72 FR 50,397, 50,407 (2007).^{*D}

Here, the relevant provisions of Virginia state law largely mirror the CSA and its regulations where they do not go beyond it. *Compare* Va. Code Ann. § 54.1-3303(C) with 21 CFR 1304.06(a). The Virginia Code requires a *bona fide* patient-practitioner relationship to exist for the issuance of any prescriptions (controlled and non-controlled) in the state. Va. Code Ann. § 54.1-3303(B). The elements of a *bona fide* patient-practitioner relationship are spelled out in the code and require that the practitioner must have:

^{*D} Omitted for brevity.

- (i) obtained or caused to be obtained a medical or drug history of the patient;
- (ii) provided information to the patient about the benefits and risks of the drug being prescribed;
- (iii) performed or caused to be performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; and
- (iv) initiated additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects.

Id.

Except in cases involving a medical emergency, the examination required pursuant to clause (iii) shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in the same group as the practitioner prescribing the controlled substance, or a consulting practitioner. *Id.* Further, all treatment, both with and without controlled substances, must be properly documented in order to fall within the standard of care as articulated by the state. Va. Admin. Code § 85-50-177 (requiring “timely, accurate, legible and complete records”). The Virginia Code also prohibits a practitioner from. . . prescrib[ing] a controlled substance to himself or a family member, other than Schedule VI as defined in § 54.1-3455 of the Code of Virginia, unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication. Va. Admin. Code § 85-50-176(B). This provision additionally specifies that when such treatment of self or family does occur, it must be properly documented to demonstrate compliance with the criteria for a *bona fide* patient-practitioner relationship. Va. Admin. Code § 85-50-176(C).

Further, the Virginia Administrative Code cites twenty-four separate categories of unprofessional conduct that can result in disciplinary action. Va. Admin. Code § 54.1-2915. Within these myriad categories, the state has prohibited: “[p]rescribing or dispensing any

controlled substance with intent or knowledge that it will be used otherwise than medically, . . . or with intent to evade any law with respect to the sale, use, or disposition of such drug;”¹⁶ violating any state or federal law “relating to the manufacture, distribution, dispensing, or administration of drugs;”¹⁷ and “[v]iolating or *cooperating with others* in violating any of the provisions of Chapters 1 (§ 54.1-100 et seq.), 24 (§ 54.1-2400 et seq.) and this chapter [(§ 54.1-2900 et seq.)] or regulations of the Board.”¹⁸ “Cooperating” is not defined in the Virginia Administrative Code, but by consciously electing to eschew the term “conspiracy,”¹⁹ it is logical to assume that Virginia seeks a broader sweep of conduct that is easier to establish.

In this case, the Respondent stipulated that he “acted outside the usual course of professional practice in Virginia by issuing controlled substance prescriptions to his wife (B.D.) without establishing a *bona fide* practitioner-patient relationship[,] by failing to perform comprehensive examinations[, and] without properly documenting the treatment of his wife (B.D.).” Stips 6, 7. Further, during the hearing, the Respondent stated that he understood and agreed with Allegations 8 -11. Tr. 133-36. Accordingly, OSC Allegations 4 and 8-11 are **SUSTAINED**.

Regarding the controlled substance prescriptions issued to the Respondent by his PA colleagues, the parties stipulated that the Respondent received controlled substance prescriptions from his PA colleagues on every date alleged in the OSC. Stips 8, 9. The Government’s theory, in essence, is that by importuning his PA colleagues to write controlled substance prescriptions for his personal use, without routing the matter through the physicians who supervise those PA practitioners, the evidence sustains the gentle standard of “cooperating with others”²⁰ to facilitate

¹⁶ Va. Admin. Code § 54.1-2915(A)(8).

¹⁷ Va. Admin. Code § 54.1-2951(A)(17).

¹⁸ Va. Admin. Code § 54.1-2951(A)(18) (emphasis added).

¹⁹ Civil conspiracy in this context requires a more rigorous showing that two or more persons combined to accomplish, by some concerted action, some criminal or unlawful purpose or some lawful purpose or some lawful purpose by a criminal or unlawful means. *Cf. Shirvinski v. United States Coast Guard*, 673 F.3d 308, 320 (4th Cir. 2012).

²⁰ Va. Code Ann. § 54.1-2915(A)(18). [Although not directly on point, it appears that the Virginia Medical Board has applied cooperating with others broadly as the Chief ALJ suggests. *See e.g., In re: Pankaj Merchia, M.D.*, Virginia Department of Health Professions, Board of Medicine, 2017 WL 2537574 (2017) (affirmed, *Pankaj Merchia v. Virginia Board of Medicine*, Va. Ct. App. 2018 WL 6313710 (2018) (not reported) (sustaining Board’s

their violation of the aforementioned state and federal laws relating to the dispensing of drugs. This aspect of the Government's theory here is enhanced by the highly-regulated nature of controlled substance prescribing and the Respondent's status as a COR holder/PA in the same office as his PA colleagues. The Respondent's awareness of standard office practices and his fellow PAs, coupled with his experience, equipped him with the knowledge of how a direct request to his colleagues would likely be received and acted upon by his PA colleagues. The Respondent freely acknowledged during the hearing that he did not have a *bona fide* practitioner-patient relationship as a patient of his PA colleagues, that they did not document the treatment they rendered to him, and that he received the controlled substance prescriptions from them outside the usual course of professional practice. Tr. 143-44. Respondent's PA colleagues also told investigators that they issued the prescriptions to the Respondent without performing a medical exam or documenting the prescriptions and treatment. *Id.* at 25-26, 57. Notably, the Respondent admitted that he took advantage of his PA colleagues because he knew he could get the scrips he wanted and that they would not document the treatment when he asked them for the scrips. *Id.* at 151-52. He described his own conduct in this regard as "unprofessional." *Id.* at 144-45. Further, in his closing brief, the Respondent stated that he "unequivocally accept[s] responsibility" for the "soliciting of controlled substance treatment from colleagues" and for "the misconduct and wrongfulness of his actions relative to the Government's allegations relating to [his] conspiracy with his colleagues." ALJX 15 at 7. Accordingly, OSC Allegations 5 and 12-14 are **SUSTAINED**.^{*E}

Inasmuch as the Respondent's state licensure and COR status are the subject of factual stipulations,²¹ OSC Allegations 1 and 2 are also **SUSTAINED**.

finding under Va. Code Ann. § 54.1-2915(A)(18)) holding a practitioner responsible for not releasing patients' medical records even though he was not in charge of the recordkeeping functions.))

^{*E} Although I agree with the Chief ALJ that substantial evidence supports these violations, and I note that Respondent did not take exception to his finding, the facts on the record regarding Respondent's unlawful prescribing to his wife over the course of several years alone offer more than enough support for my ultimate conclusion that Respondent's registration is inconsistent with the public interest.

²¹ Stips. 1, 2, 3.

Thus, a balancing of Factors Two and Four militate strongly in favor of the imposition of the revocation sanction sought by the Government.

III. SANCTION

The evidence of record preponderantly establishes that the Respondent has committed acts which render his continued registration inconsistent with the public interest. *See* 21 U.S.C. 824(a)(4). Since the Government has met its burden²² in demonstrating that the revocation it seeks is authorized, to avoid sanction, it becomes incumbent upon the Respondent to demonstrate that given the totality of the facts and circumstances revocation is not warranted. *See Med. Shoppe-Jonesborough*, 73 FR at 387. That is, upon the preponderant establishment of the Government's *prima facie* case, the burden shifts to the Respondent to show why he should continue to be entrusted with a DEA registration. *See Kaniz F. Khan-Jaffery, M.D.*, 85 FR 45,667, 45,689 (2020); *Garrett Howard Smith, M.D.*, 83 FR 18,882, 18,910 (2018). Although by no means the only requirement, in order to rebut the Government's *prima facie* case, the Respondent must demonstrate not only an unequivocal acceptance of responsibility but also a demonstrable plan of action to avoid similar conduct in the future. *See Hassman*, 75 FR at 8236. While those two elements are key, the focus is, and must always be, rooted in a determination as to whether the Agency can have confidence that the Respondent can continue to be entrusted with the weighty and dangerous responsibilities of a registrant. *Cf., Khan-Jaffery, M.D.*, 85 FR at 45,689; *Smith, M.D.*, 83 FR at 18,910. While analytical frameworks applied to prior Agency actions provide useful guidance and helpful structure, such tools cannot distract the Agency from its critical mission to keep the public safe by only issuing and maintaining CORs in cases where the public is adequately protected.

Agency decisions are clear that a respondent must "unequivocally admit fault" as opposed to a "generalized acceptance of responsibility." *The Medicine Shoppe*, 79 FR 59,504, 59,510 (2014); *see also Lon F. Alexander, M.D.*, 82 FR 49,704, 49,728 (2017). To satisfy this

²² *See* 21 C.F.R. § 1301.44(e).

burden, the respondent must “show true remorse” or an “acknowledgment of wrongdoing.” *Leslie*, 68 FR at 15,528. The Agency has made it clear that unequivocal acceptance of responsibility is paramount for avoiding a sanction. *Robert L. Dougherty, M.D.*, 76 FR 16,823, 16,834 (2011) (citing *Krishna-Iyer*, 74 FR at 464). This feature of the Agency’s interpretation of its statutory mandate on the exercise of its discretionary function under the CSA has been sustained on review. *Jones Total Health Care Pharmacy, LLC v. DEA*, 881 F.3d 823, 830-31 (11th Cir. 2018); *MacKay v. DEA*, 664 F.3d 808, 822 (10th Cir. 2011); *Hoxie*, 419 F.3d at 483.

A. Acceptance of Responsibility

On the issue of acceptance, although (as discussed, *supra*) the Respondent’s testimony carried with it an intermittently confusing quality, it could not be fairly said that, taken as a whole (to include, at least to some extent, the attorney-authorized admissions in his closing brief)²³ that the Respondent did not accept responsibility. He did.^{*F}

Regarding the required demonstration of remedial measures aimed at the avoidance of recurrence, the Respondent (predictably) promised that he would foreswear prescribing to his wife, friends, and relatives, and would presumably no longer seek to importune colleagues to authorize the dispensing of powerful drugs for his personal use. Additionally, the Respondent completed a three-day professional boundaries course, participated in the Phone Follow-up Exercise, and took an opiate prescribing course. RX 2-4.^{*G} A fundamental issue here is not so

²³ ALJX 15.

^{*F} I agree with the Chief ALJ that Respondent generally accepted responsibility, did not make excuses, pass blame or mitigate his misconduct—other than perhaps in his self-portrayal as merely someone who has trouble saying “no.” See *infra* III.B. It is noted that prior Agency decisions have made it clear that in order to avoid sanction once the Government has established a *prima facie* case, a registrant must do more than say the right thing on the stand and in filings. “The degree of acceptance of responsibility that is required does not hinge on the respondent uttering “magic words” of repentance, but rather on whether the respondent has credibly and candidly demonstrated that he will not repeat the same behavior and endanger the public in a manner that instills confidence in the Administrator.” *Jeffrey Stein, M.D.*, 84 FR 46,968, 49,973 (2019).

^{*G} Further, I note that these courses were specifically marked with American Medical Association (AMA) credits, which as Respondent admitted were “the type of credits we all need for continuing education.” Tr. 121. Although the subject matter of the courses is certainly relevant to Respondent’s compliance with the CSA, and in particular, relevant to correcting his misconduct, I do not find significant value to the important question of whether he can be entrusted with a CSA registration in remedial measures that meet continuing education requirements. The record did not expand on whether he had used these credits for that purpose. If he had, that would certainly weigh against

much that the Respondent did not make a remedial plan of sorts, the issue is that the record demonstrates no information that the Respondent learned in the courses what he admittedly did not know while he was committing the misconduct. That is to say, he required no course to provide him with the revelation that writing prescriptions for powerful pain medications to his non-patient wife was a breach of his state and federal obligations. It was obvious that he knew this was the case by the deceitful practices he employed in alternating between his wife's maiden and married names. He admitted that the entire enterprise was causing him consternation, and yet he persevered in this unprofessional debacle for four-and-a-half years. Likewise, he did not suddenly gain understanding that having his PA colleagues (one of whom he was mentoring) prescribe controlled substances for him was beyond the pale. The Respondent understood every one of these lessons at the outset of the story. No moment of sudden realization and enlightenment was borne of two courses and a Phone Follow-up Exercise. The problem is that the Respondent is as aware of his obligations now as he was when his professional life spiraled out of control. A registrant who gains specialized knowledge in the intricacies of documentation from coursework, or incorporates process changes in his/her practice to address a diversion risk are examples of scenarios where a remedial plan can carry significant influence. On this record, where the Respondent knew what to do during every moment of the period in question, the weight that can logically be attached to his remedial steps must be significantly diminished. Stated differently, he knew then and he knows now, and the "remedial plan" offered here is essentially an exercise in going through the motions.

B. Specific and General Deterrence

The issue here is appropriately resolved in the remaining guideposts of the Agency's analytical framework. In determining whether and to what extent imposing a sanction is appropriate, consideration must be given to the Agency's interest in both specific and general

my consideration of them as remedial measures in this action. However, even if he did not use them for this dual purpose, I agree with the Chief ALJ that the remedial plan that Respondent offered was not adequate to ensure that I can entrust him with a registration.

deterrence and the egregiousness of the offenses established by the Government's evidence. *Ruben*, 78 FR at 38,364, 38,385. Each of these concepts bears separate consideration here. It is reasonable to conclude that, at least for the present, the Respondent is unlikely to re-commit these specific transgressions. His wife is being treated by a qualified physician (who is not prescribing controlled substances), and his former coworkers presumably know enough now not to trust him in the future. Thus, the issue of specific deterrence does not particularly favor the imposition of a sanction here. [The Chief ALJ found that specific deterrence does not particularly favor the imposition of a sanction here. Although I agree that Respondent might not be able to repeat the exact same behavior he conducted, I am not convinced by his remedial measures or the minimal consequences that he has faced thus far that he will not repeat similar behavior in mishandling his registration for personal gain. There is ample evidence on the record that Respondent knew what he was doing was unlawful. He admits as much. As discussed herein, he repeated the misconduct in prescribing controlled substances to his wife for several years, and made efforts to hide his behavior. He preyed on his colleague whom he had mentored—taking advantage of the imbalance of power in their relationship in order to obtain controlled substances when his own doctor had denied them. When Respondent proclaimed that he “is not the yes guy anymore,” Tr. 126, due to his apparently-enlightening ethics class, he implied that his misbehavior was linked to a lack of boundaries due to his over-accommodating personality, and he urged me to believe that suddenly he has re-established those boundaries—that he has broken “the habit and create[d] new habits to be able to perform within professional boundaries.” Tr. 118. However, contrary to this favorable self-portrayal, the egregious behavior on the record demonstrates more artful and intentional deceit than simply refusing to say no. All of the misconduct herein occurred after practitioners acting in the course of their professional practice had refused to prescribe controlled substances. *See* Tr. 138. Further, Respondent covered his tracks and manipulated relationships. As sympathetic as Respondent would make the situation sound—that he “wanted to help [his wife],” who was in pain, Tr. 142—the fact is

that he repeatedly demonstrated behavior that is untrustworthy. I am not convinced that the few days of training that he took in ethics was so impactful as to have reformed him in the manner that he suggests. Therefore, I find that the issue of specific deterrence weighs in favor of revocation.

Regarding general deterrence,] as the regulator in this field, the Agency bears the responsibility to deter similar misconduct on the part of others for the protection of the public at large. *Ruben*, 78 FR at 38,385. To the extent that no sanction is imposed, the unambiguous message to the regulated community would be that four-and-a-half years of enabling the (apparently inappropriate) use of powerful controlled drugs for a spouse, while employing the artifice of alternating scrip names, and only stopping when state and federal regulatory authorities are tipped off by a pharmacist, carries with it no consequence. The Respondent's case in this regard might have been somewhat fortified if the level of cunning or the duration of the malfeasance had been more constrained, but the record is what it is.

C. Egregiousness

Considerations of egregiousness likewise support revocation. The Respondent carried on prescribing for his wife (even during her pregnancy) for four-and-a-half years, which is a significant amount of time to carry on with conduct that a person knows is straight-up wrong. The prescribing was not a one-off, an act of momentary desperation, or a misguided accident borne of professional ignorance, and there was no eureka moment. Like pressing his advantage with the PA colleague he mentored, the Respondent's acts were consistently intentional. The intentional nature of the Respondent's acts undermines the ability of the Agency, at least at present, to have confidence that he will responsibly exercise the responsibilities of a DEA registrant.

Accordingly, it is respectfully recommended that the Respondent's DEA COR should be **REVOKED**, and any pending applications for renewal should be **DENIED**.

Dated: December 8, 2020.

JOHN J. MULROONEY, II

Chief Administrative Law Judge

ORDER

Pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 824(a)(4) and 21 U.S.C. 823(f), I hereby revoke DEA Certificate of Registration No. MD3130717 issued to Noah David, P.A. Further, pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 824(a) and 21 U.S.C. 823(f), I hereby deny any pending application of Noah David, P.A. to renew or modify this registration, as well as any other pending application of Noah David, P.A. for registration in Virginia. This Order is effective [INSERT DATE 30 DAYS FROM THE DATE OF PUBLICATION IN THE FEDERAL REGISTER].

Anne Milgram,
Administrator.

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